Medical Records Release Form

Bloomsburg University
Student Health Center
(570) 389-4451 (P)
(570) 389-3417 (F)

Room 324 Kehr Union Building
400 E. Second Street
Bloomsburg, PA 17815

I understand that my medical record may contain information related to alcohol/drug abuse, mental health/rehabilitation, HIV/AIDS, and/or sexual assault. This information will be disclosed unless I specify that the information **NOT** be disclosed by initialing below.

☐ Alcohol/Drug Abuse ☐ Mental Health/Rehabilitation ☐ HIV/AIDS ☐ Sexual Assault

_____ _____
Student's Name (Please Print) BU ID#

(_____)_____ _____
Telephone # Date of Birth

_____
Address City/State/Zip

I authorize the Student Health Center to DISCLOSE/VERBALLY DISCLOSE/RECEIVE Protected Health Information contained in my medical record ☐ TO - ☐ FROM (please initial):

_____
Name/Organization

_____
Address City/State/Zip

(_____)_____ (_____)_____
Telephone # Fax #

The information released shall include documentation from my medical record from _____through_____.
Date **Date**

Information to be disclosed (please check the appropriate boxes):

- o Immunizations
- o Clinic Notes
- o Lab reports
- o X-ray reports
- ○ TB tests
- ○ Physical
- ○ Other_____

Reason for which I am authorizing disclosure:

o Continuation of care ○ Payment of a claim ○ Personal Use ○ Other_____

I understand that I may revoke this authorization at any time by notifying the Student Health Center in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. If I fail to specify an expiration date, this authorization will expire 60 days from the date on which it was signed.

I understand authorizing the use or disclosure of the information identified above is voluntary and I may inspect or copy information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.

I understand that records and reports generated by other medical facilities cannot be copied and released to me. To obtain these reports, I must request copies from the originating medical facilities.

_____ _____ _____
Signature of Patient or Legal Representative Date Legal Representatives Relationship to Patient

OFFICE USE ONLY

Records Sent/Released: _____
Date Initials